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Notice of Independent Review Decision

DATE OF REVIEW: 8/24/12

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left sacroiliac joint injection w/CT guided sagital, coronal & axial w/sedation for diagnostics and surgery. Outpatient. CPT: 27096, 77003, 72193, 99144

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified in **Anesthesiology and Pain Management.**

DESCRIPTION OF THE REVIEW OUTCOME THAT CLEARLY STATES WHETHER OR NOT MEDICAL NECESSITY EXISTS FOR EACH OF THE HEALTH CARE SERVICES IN DISPUTE.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	**(Agree)**	**X**
Overturned	(Disagree)	
Partially Overturned	(Agree in part/Disagree in part)	

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Pre-authorization Decision & Rationale: 7/12/12, 7/02/12
Prospective Review (IRO) Response: 8/16/12
Adjustor Summaries: TASB, 7/02/12 - 10/10
Clinical Notes: 6/18/12 - 3/22/12; 7/26/11; 11/18/10 - 8/23/10
Radiology/MRI Spine Rpt., 8/23/10 - 4/28/09
Operative Rpt, 4/26/12
ODG

PATIENT CLINICAL HISTORY SUMMARY

This was injured in a motor vehicle accident. He has persistent low back pain and the patient indicates that it is not necessarily site specific. An MRI shows multi-level disc degeneration. Physical therapy has been provided along with facet rhizotomy, epidural steroid injections and medications. A discogram was performed and was deemed to be non-diagnostic.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION

I agree with the benefit company's decision to deny the services. **Rationale**: ODG require 3 positive physical exam findings to justify a sacroiliac joint injection. The physical exam does not demonstrate 3 positive findings. ODG specify fluoroscopy for SI joint injections. The procedure was requested under CT guidance which is not indicated for ODG. Therefore, ODG are not met for the requested procedure.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

M**EDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)